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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146028	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Estates of Lincolnshire	150 Jamestown Lane Lincolnshire, IL 60069

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541 Based on interview and record review the facility failed to include a resident in her care plan meetings for 1 of 4 residents (R7) reviewed for resident rights/right to participate in their plan of care in the sample of 12. The findings include: R7's current care plan dated showed R7 was admitted to the facility, on 10/10/24, with diagnoses of diabetes, right leg above-the-knee (AKA) amputation, and wounds to her sacrum and left foot. The plan showed R7 had no advanced directives and/or POA (power of attorney). The plan showed R7 had a hearing impairment. (R7) is able to express personal needs/wants Speak slowly and clearly (to R7) . R7's resident assessment dated [DATE] showed R7 was cognitively intact. On 3/10/25 at 9:50 AM, R7 was seated in a wheelchair in her room. R7 was interviewed by this surveyor with no hearing difficulties noted from R7 as this surveyor spoke slowly and directly into R7's right ear. This surveyor did not have to yell to be heard by R7. R7 stated she was upset because they had a meeting last week but didn't include me. They said my daughter could go instead of me because I couldn't hear anyway. That's not okay. I can hear. They just have to get close to me . I have told (V14 Social Services) I don't want him speaking to my daughter without me present . I don't want want them (her family) knowing my business . A Social Service noted dated 2/10/25 showed V14 Social Services contacted resident's daughters to discuss resident's financial affairs. Currently, there is no (POA) on file for the resident. Be that as it may, resident experiences communication challenges due to hearing difficulties . R7's Care Plan Attendance sign-in sheet dated 2/15/25 showed the meeting was attended by a daughter of R7, V14 Social Services, V2 Director of Nursing (DON), V15 Business Office Manager, and a representative from the skilled therapy department. The sign-in sheet showed R7 did not attend the meeting. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/25 at 10:50 AM, V14 Social Services stated, We did have a meeting a couple of weeks ago for (R7) but (R7) was not there for the meeting. I was worried about HIPAA (Health Insurance Portability and Accountability Act) because someone could overhear us talking because (R7) can't hear and I would have to yell. V14 stated that during the meeting, POA paperwork and R7's leg prosthetic was discussed with R7's daughter. V14 stated, Yes, (R7) has told me she wants to be included in all of the meetings. She does not have a POA. She is cognitively intact but again, I was worried about HIPAA V14 stated a communication board was located the nurses station for residents that are hard of hearing or have communication difficulties but he had never used the board to communicate with R7. On 3/10/25 at 11:50 AM, V1 Administrator stated all residents should be invited to and included in all of their care plan meetings. The facility's Resident Rights policy dated 9/1/24 showed, The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility . The resident has the right to be informed of, and participate in, his or her treatment, including: . The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: i. The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40798 Based on observation, interview, and record review, the facility failed to ensure interventions were implemented to prevent/heal pressure ulcers for 2 of 3 residents (R1 and R11) reviewed for wounds in the sample of 12. The findings include: On 3/10/25 at 10:51 AM, R1 was lying in bed. He did not have a low air loss mattress. On 3/10/25 at 1:41 PM, R11 was lying in bed. She did not have a low air loss mattress. R1's Admission Record dated 3/11/25 shows R1 was admitted to the facility on [DATE]. R1's Wound Assessment Details Report dated 2/27/25 shows R1 was admitted with a Stage 4 pressure ulcer of his sacrum measuring 5.0 centimeters (cm) by 6.5 cm by 2.0 cm and a Stage 3 pressure ulcer of his left ischial tuberosity measuring 5.0 cm by 5.2 cm by 0.30 cm. R1's Order Summary Report dated 3/11/25 shows an order for a pressure relieving mattress ordered on 2/26/25. R11's Admission Record dated 3/11/25 shows R11 was admitted to the facility on [DATE]. R11's Wound Assessment Details Report dated 2/26/25 shows R11 was admitted with a Stage 3 pressure ulcer of her sacrum measuring 2.5 cm by 0.60 cm by 0.10 cm. R11's Order Summary Report dated 3/11/25 shows an order for a pressure relieving mattress ordered on 2/25/25. On 3/11/25 at 11:00 AM, V17, Wound Care Nurse, said R1 and R11 should both have gotten a low air loss mattress since R1 has a Stage 4 pressure ulcer and R11 has a Stage 3 pressure ulcer. V17 said she told maintenance R1 and R11 needed a low air loss mattress. The facility's Pressure Injury Prevention and Management Policy (revised 10/23/24) shows the facility is committed to provide treatment and services to heal the pressure ulcer and prevent the development of additional pressure ulcers.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35541 Based on observation, interview and record review the facility failed to ensure a resident was supervised while ambulating which contributed to the resident sustaining a fall for 1 of 3 residents (R8) reviewed for supervision/falls in the sample of 12. The findings include: A facility fall incident report dated 2/27/25 showed R8 sustained an un-witnessed fall in the facility. The report showed, Resident was ambulating by herself in the hallway when writer heard her start crying and observed resident lying on the floor on her right side . R8 was unable to state what happened due to her impaired cognition. Swelling and redness was noted to R8's forehead. R8 was sent to the hospital for an evaluation post-fall. R8 returned to the facility, from the hospital, with no injuries noted from the fall. R8's current care plan showed R8 was at risk for falls due to her diagnoses of dementia, Alzheimer's Disease, recurrent psychosis, and anorexia. The plan showed R8 required staff supervision for transfers and toileting. The plan showed, She is able to walk with no assistive device with supervision. R8 was severely cognitively impaired. On 3/10/25 at 10:24 AM, R8 was seated at a dining table on a secured unit of the facility. A large, circular, yellow-green bruise was noted to R8's right forehead area. An attempt to interview R8 was unsuccessful due to R8's impaired cognition. At 10:35 AM, V3 Assistant Director of Nursing (ADON) was standing by R8. V3 was asked about the bruise to R8's forehead. V3 stated R8 recently had a fall. V3 stated, She needs to be supervised because she is a fall risk and will try to get up and walk on her own. She wanders. We keep her out by the nurses station so staff can keep an eye on her. The facility's nursing schedule dated 2/27/25 showed V10 Registered Nurse (RN), V11 Certified Nursing Assistant (CNA), and V12 CNA were assigned to R8's unit at the time of R8's fall. On 3/10/25 at 12:08 PM, V12 CNA stated she was on lunch and not on the unit at the time of R8's fall. On 3/10/25 at 1:35 PM, V11 CNA stated he was not on the unit at the time of R8's fall. V11 stated, I was the float CNA that night so I was on the other unit at the time taking care of other residents . V11 stated he was aware that R8 needed supervision due to her being a fall risk and history of wandering throughout the unit. On 3/11/25 at 9:20 AM, V10 RN stated, I did see (R8) walking in the hallway that night but I was busy passing meds. I was in a room giving meds when she fell . I came out of a room and found her lying by a dining table. I was the only staff on the unit at the time. I couldn't watch her and pass meds at the same time Yes, if a CNA had been on the floor with me, we could have been watching her and potentially prevented her from falling.